CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

CHAPTER II
TABLE OF CONTENTS

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PARTICIPATING PROVIDER

A participating provider is an institution, facility, agency, person, partnership, corporation, or association that is licensed or certified by the appropriate state agency and has a current, signed participation agreement with the Department of Medical Assistance Services (DMAS). See the "Exhibits" section at the end of this chapter for a sample of the agreement.

PROVIDER ENROLLMENT

Each provider of services must be enrolled in the Medicaid Program prior to billing DMAS for any services provided to Medicaid recipients. A sample copy of the Durable Medical Equipment and Supplies Provider Participation Agreement is included in the "Exhibits" section at the end of this chapter. All providers must sign the appropriate Participation Agreement and return it to the First Health Provider Enrollment Unit; an original signature of the individual provider is required. The participation agreement is not time-limited, and will only expire upon the lapse or loss of licensure or certification of the provider, action taken by DMAS to meet the requirements of the agreement, regulations or law, inactive participation by the provider (no billing within 36 months), or resignation by the provider. DMAS will request a copy of the renewed licensure/certification prior to its expiration.

In addition, the providers must submit a copy of a current business license or a copy of a current license through the Virginia Board of Pharmacy, if invasive products are distributed.

Upon receipt of the above information, a provider number is assigned to each approved provider. See the "Provider Identification Number" section in this chapter for additional information.

This manual contains instructions for billing and specific details concerning the Medicaid Program. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

REQUESTS FOR PARTICIPATION

To become a Medicaid provider of services, providers must obtain separate provider identification numbers for each physical or servicing location wanting to offer services to Virginia Medicaid recipients. The provider must request the participation agreement(s) by writing, telephoning, or faxing their requests to:

First Health
VMAP-PEU
PO Box 26803
Richmond, VA 23261-6803

1-(804) 270-5105 Toll free in state only - 1-(888) 829-5373
FAX (804) 270-7027

Requests will be screened to determine whether the applicant meets the basic requirements for participation (e.g., Medicare/Medicaid Home Health Certification and adequacy and experience of staff).

An application for private duty nursing provider status and information regarding provider participation requirements and standards will be mailed to any interested party who requests information or an application to become a Medicaid-approved provider for private duty nursing and who meets the basic requirements for participation. A copy of this application is included in the "Exhibits" section at the end of this chapter.

DMAS contracts with FIRST HEALTH/Provider Enrollment Unit (FH/PEU) to perform provider enrollment duties. Once FH/PEU receives and reviews an application and determines that the provider meets all the requirements for Medicaid private duty nursing provider participation, FH/PEU will send the provider a copy of the agreement for review and signature. The provider agreement must be returned to FH/PEU with an original signature of the provider's administrative staff or person authorized to bind the provider under contract.

PROVIDER IDENTIFICATION NUMBER

Upon receipt of the signed agreement and upon approval and signature by DMAS/FHS, a provider identification number will be assigned. The provider will be sent a copy of the agreement and the assigned provider identification number. This number must be used on all billing invoices and correspondence submitted to DMAS. All physical locations must obtain their own separate provider identification number. This number must be used on all claims and correspondence submitted to Medicaid. DMAS will not reimburse the provider for any services rendered prior to the assignment of this provider identification number (ID).

PARTICIPATION REQUIREMENTS

Providers approved for participation in the Medical Assistance Program must perform the following activities as well as any other specified by DMAS:

- Immediately notify First Health Services Provider Enrollment Unit (FH/PEU) in writing, of any change in the information which the provider previously submitted to FH/PEU.

- Assure freedom of choice to recipients in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in the Medicaid Program at the time the service was performed.

- Assure the recipient's freedom to reject medical care and treatment.

- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the ground of race, color, or national origin.

- Provide services, goods, and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities.

- Provide services and supplies to recipients of the same quality and in the same mode of delivery as provided to the general public.

- Charge DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public.

- Accept as payment in full the amount established by DMAS. 42 CFR § 447.15 requires that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the state. A provider may not seek to collect from a Medicaid recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established Medicaid allowance for the service rendered.

  For example, if a third party payer reimburses $5 of an $8 charge, and Medicaid's allowance is $5, then payment in full of the Medicaid allowance has been made. The provider may not attempt to collect the $3 difference.

  The provider may not bill the recipient or DMAS for broken or missed appointments;

- Accept assignment of Medicare benefits for eligible Medicaid recipients.

- Use Program-designated billing forms for submission of charges.

- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. Such records shall be maintained in a designated business office from which all private duty nursing provider agency business is conducted.

  In general, such records must be retained for a period of not less than five years

from the last date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. Records of minors must be kept for at least five (5) years after such minor has reached the age of 18 years. (Refer to the "Documentation of Records" section.)

- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities.

- Disclose, as requested by the Program, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of medical assistance.

- Hold confidential and use for authorized DMAS purposes only all medical assistance information regarding recipients. A provider shall disclose information in his or her possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public.

PARTICIPATION REQUIREMENTS FOR EQUIPMENT AND SUPPLIES RELATED TO VENTILATORS

A medical equipment and supply provider must meet the following requirements for the provision of any durable medical equipment and supplies related to the care of a ventilator maintained in the home of an individual.

- The provider must employ or contract with a registered or certified respiratory therapist who will be available on a 24-hour-a-day basis for emergency care. The respiratory therapist should be stationed within two (2) hours of the patient's home to facilitate an immediate response.

- The provider must employ or contract with technicians to make regularly scheduled maintenance visits.

- The provider must perform replacement or repair of the equipment and supplies as required.

- The provider must submit a copy of a current business license or a copy of a current license through the Virginia Board of Pharmacy if invasive products are distributed.

- The provider must provide instruction and training to caregivers.

Respiratory therapists must be either certified or registered by the National Board for

Respiratory Care (NBRC).

The respiratory therapist must provide a monthly home visit for all individuals receiving equipment and supplies related to the care of the ventilator. This visit must be documented to include all of the following information:

- A respiratory assessment;
- A note of any instructions given to the caregiver;
- The ventilator model identification, settings, and schedule; and
- A note that the equipment has been checked, and the required information has been posted in the home.

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), provides that no disabled individual shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each Medicaid provider is responsible for making provision for individuals with disabilities in its program activities.

In the event a discrimination complaint is lodged, DMAS is required to provide to the federal Office of Civil Rights (OCR) any evidence regarding compliance with these requirements.

DOCUMENTATION OF RECORDS

The provider agreement requires that the record fully disclose the extent of services provided to Medicaid recipients. The following elements are required:

- The record must identify the patient on each page, and
- Entries must be signed and dated by the responsible participating provider.

Detailed information about documentation requirements is provided in Chapter VI of this manual.

TERMINATION OF PROVIDER PARTICIPATION

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to the Director, Department of Medical Assistance Services, and FH/PEU thirty (30) days prior to the effective date. The addresses are:

Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

First Health
VMAP-PEU
PO Box 26803
Richmond, VA 23261-6803

DMAS may terminate a provider from participating upon thirty (30) days written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to customers subsequent to the date specified in the termination notice.

A copy of this written notification must be sent to the following unit:

Facility and Home Based Services Unit
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

RECONSIDERATION AND APPEALS OF ADVERSE ACTIONS

Non-State Operated Provider

The following procedures will be available to all non-state operated providers when DMAS takes adverse action such as termination or suspension of the provider agreement or denial of payment for services rendered based on utilization review decisions.

The reconsideration and appeals process will consist of three phases: a written response and reconsideration to the preliminary findings, the informal conference, and the formal evidentiary hearing. The provider will have 30 days to submit information for written reconsideration and will have a 30-day notice to request the informal conference and/or the formal evidentiary hearing.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (§§ 2.2-4000 et seq. of the Code of Virginia)(the APA) and the *State Plan for Medical Assistance* provided for in § 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the APA.

Any legal representative of a provider must be duly licensed to practice law in the Commonwealth of Virginia.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement and

denial of payment for services rendered based on utilization review decisions. State-operated provider means a provider of Medicaid services which is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration for any issue which would be otherwise administratively appealable under the *State Plan* by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: an informal review by the Division Director, DMAS Director review, and Secretarial review. First, the state-operated provider will submit to the appropriate DMAS Division, written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives its Notice of Amount of Program Reimbursement, notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought; the amount of the adjustment sought; and the reasons for seeking the adjustment. The Division Director will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution. Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable law and regulations. The Division Director will consider any recommendation of his or her designee and render a decision.

A state-operated provider may, within 30 days after receiving the informal review decision of the Division Director, request that the DMAS Director or his designee review the decision of the Division Director. The DMAS Director has the authority to take whatever measures he or she deems appropriate to resolve the dispute.

If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 days after receipt of the decision of the DMAS Director, the provider may request the DMAS Director to refer the matter to the Secretary of Health and Human Resources or any other Cabinet Secretary as appropriate. Any determination by such Secretary or Secretaries will be final.

TERMINATION OF A PROVIDER CONTRACT UPON CONVICTION OF A FELONY

Subsection (c) of § 32.1-325 of the Code of Virginia mandates that "Any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify DMAS of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

REPAYMENT OF IDENTIFIED OVERPAYMENTS

Pursuant to § 32.1-325.1 of the Code of Virginia, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When a lump sum cash payment is not made, interest will be added

on the declining balance at the statutory rate, pursuant to the § 32.1-313.1 of the Code of Virginia. Repayment and interest will not apply pending appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates to the satisfaction of DMAS, a financial hardship warranting extended repayment terms.

MEDICAID PROGRAM INFORMATION

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives program information.

A provider may not wish to receive provider manuals or Medicaid memoranda because he or she has access to the publications as a part of a group practice. To suppress the receipt of this information, the First Health Provider Enrollment Unit requires the provider to complete the Mailing Suspension Request form and return it to:

First Health Provider Enrollment Unit
P.O. Box 26803
Richmond, VA 23261-6803

See the "Exhibits" section at the end of this chapter for a sample of the Mailing Suspension Request form.

Upon receipt of the completed form, FH-PEU will process it, and the provider named on the form will no longer receive publications from DMAS. To resume the mailings, a written request sent to the same address is required.

EXHIBITS

TABLE OF CONTENTS

Commonwealth of Virginia
Department of Medical Assistance Services
Medical Assistance Program

Durable Medical Equipment and Supplies Participation Agreement

If re-enrolling, enter Medicaid Provider Number here→ _____ Check this box if requesting new number→ ☐

This is to certify:	**PAYMENT/CORRESPONDENCE ADDRESS**	**PHYSICAL ADDRESS (*REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS*)**
NAME		
ATTENTION		
ADDR LINE 1		
ADDR LINE 2		
CITY, STATE, ZIP		

on this _____day of _____ , _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

Supplies dispensed require a Virginia Department of Health Professions Permit? One of the boxes must be checked.

☐ No. Copy of business license is enclosed.
☐ Yes. Pharmacy or Medical Equipment Supply DHP permit number is listed in the appropriate field below.

1. Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his handicap be excluded from participation in, be denied the benefits of, or be subjected to discrimination in Section 504 of the Rehabilitation Act of 1973 (29 §USC 794) VMAP.
2. Services rendered must be those provided according to a physician's written order. Payment is to be made only to those providers who actually render the services. Upon accepting a Medicaid recipient as a patient, the provider agrees to supply all items prescribed and authorized for the recipient which the provider supplies to the general public.
3. The provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the state plan. Access to records and facilities by authorized VMAP representatives, the Attorney General or his authorized representatives, and federal personnel will be permitted under reasonable request.
4. The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.
5. Payment by VMAP at its established rates for services covered constitutes full payment on behalf of the recipient. The provider agrees not to submit additional charges to the recipient for services covered by VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited.
6. The provider agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.
7. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.
8. The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended.
9. The provider of respiratory ventilator equipment agrees to provide authorized maintenance and preventive services for ventilators belonging to VMAP recipients.
10. This agreement may be terminated at will on thirty days' written notice by either party or by VMAP when the provider is no longer eligible to participate in the Program.
11. All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.

12. **This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your licensing authority shall result in the termination of your Medicaid Participation Agreement.**

For First Health's use only

Director, Division of Program Operations Date

For Provider of Services:

Original Signature of Provider **Date**

_____City or _____County of

IRS Identification Number **(Area Code) Telephone Number**

IRS Name (required)

Pharmacy Permit Number (VA Board of Pharmacy) ***OR*** **DME Permit Number (VA Board of Pharmacy)**

mail **one** completed **original** agreement to: **First Health - VMAP-Provider Enrollment Unit**
PO Box 26803
Richmond, Virginia 23261-6803

Medicare Carrier and Vendor Number

First Health Services Corporation

MAILING SUSPENSION REQUEST
SERVICE CENTER AUTHORIZATION
SIGNATURE WAIVER
PHARMACY POINT-OF-SALE

Please review and check the blocks which pertain to you:

- ☐ **MAILING SUSPENSION REQUEST:**
  I do not wish to receive Medicaid memos, forms, or manual updates under the Medicaid provider number given below.

- ☐ **COMPUTER GENERATED CLAIMS:**
  I certify that I have authorized the following service center to submit computer-generated invoices (by modem, diskette or tape) to Virginia Medicaid:

  _____
  (Service Center Preparing Invoices)

  Service center code: _____ **Magnetic Tape RA:** YES NO (Circle One)

  Prior service center code: _____

- ☐ **SIGNATURE WAIVER:**
  I certify that I have authorized submission of claims to Virginia Medicaid which contain my typed, computer generated, or stamped signature.

- ☐ **PHARMACY POINT-OF-SALE AUTHORIZATION (in-state providers only):**
  I wish to submit Point-of-Sale billings to Virginia Medicaid.

I understand that I am responsible for the information presented on these invoices and that the information is true, accurate, and complete. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws.

PROVIDER NAME: _____

PROVIDER NUMBER: _____ Leave blank, if number pending.

SIGNATURE: _____

DATE: _____

TELEPHONE # _____

Please return completed form to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803
1-804-270-5105